BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against:	)	
AYTAC HILMI APAYDIN, M.D.	)	Case No. 03-2013-234324
Physician's and Surgeon's Certificate No. A 46632	)	
Respondent	)	

DECISION AND ORDER

The attached Stipulated Settlement and Disciplinary Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on January 19, 2018.

IT IS SO ORDERED: December 22, 2017.

MEDICAL BOARD OF CALIFORNIA

Ronald H. Lewis, M.D., Chair
Panel A

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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: **AYTAC HILMI APAYDIN, M.D.** **1115 Los Palos Drive** **Salinas, CA 93901** **Physician's and Surgeon's Certificate** **No. A 46632** Respondent.	Case No. 03-2013-234324 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board of California (Board). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Jane Zack Simon, Supervising Deputy Attorney General.

2. Respondent Aytac Hilmi Apaydin, M.D. (Respondent) is represented in this proceeding by attorney Thomas E. Still, Esq., whose address is: Hinshaw, Marsh, Still & Hinshaw, LLP, 12901 Saratoga Avenue, Saratoga, CA 95070-9988.

3. On or about October 23, 1989, the Board issued Physician's and Surgeon's Certificate No. A 46632 to Aytac Hilmi Apaydin, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in First Amended Accusation No. 03-2013-234324 (hereinafter "Accusation"), and will expire on April 30, 2019, unless renewed.

JURISDICTION

4. Accusation No. 03-2013-234324 was filed before the Board, and is currently pending against Respondent. The original Accusation and all other statutorily required documents were properly served on Respondent on November 17, 2015. Respondent timely filed his Notice of Defense contesting the Accusation. The First Amended Accusation was properly served on Respondent on November 1, 2017.

5. A copy of Accusation No. 03-2013-234324 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 03-2013-234324. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

8. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

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CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 03-2013-234324, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. For purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges in the Accusation, and that Respondent hereby gives up his right to contest those charges.

11. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and he agrees to be bound by the Board's imposition of discipline as set forth in the Disciplinary Order below.

CONTINGENCY

12. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

13. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

14. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 46632 issued to Respondent Aytac Hilmi Apaydin, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for five (5) years on the following terms and conditions.

1. EDUCATION COURSE. Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

2. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

3. PROFESSIONALISM PROGRAM (ETHICS COURSE). Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358.1. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after Respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A professionalism program taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the program would have been approved by the Board or its designee had the program been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the program or not later than 15 calendar days after the effective date of the Decision, whichever is later.

4. CLINICAL COMPETENCE ASSESSMENT PROGRAM. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully complete the program not later than six (6) months after Respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The program shall consist of a comprehensive assessment of Respondent's physical and mental health and the six general domains of clinical competence as defined by the Accreditation

Council on Graduate Medical Education and American Board of Medical Specialties pertaining to Respondent's current or intended area of practice. The program shall take into account data obtained from the pre-assessment, self-report forms and interview, and the Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. The program shall require Respondent's on-site participation for a minimum of three (3) and no more than five (5) days as determined by the program for the assessment and clinical education evaluation. Respondent shall pay all expenses associated with the clinical competence assessment program.

At the end of the evaluation, the program will submit a report to the Board or its designee which unequivocally states whether the Respondent has demonstrated the ability to practice safely and independently. Based on Respondent's performance on the clinical competence assessment, the program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, evaluation or treatment for any medical condition or psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with the program's recommendations.

Determination as to whether Respondent successfully completed the clinical competence assessment program is solely within the program's jurisdiction.

If Respondent fails to enroll, participate in, or successfully complete the clinical competence assessment program within the designated time period, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical competence assessment program have been completed. If Respondent did not successfully complete the clinical competence assessment program, Respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

5. MONITORING - PRACTICE. Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice

monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitors shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine, and whether Respondent is practicing medicine safely. It shall be the sole responsibility of Respondent to ensure that the monitor submits the

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quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, Respondent may participate in a professional enhancement program approved in advance by the Board or its designee that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

6. NOTIFICATION. Within seven (7) days of the effective date of this Decision, Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

7. SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSES. During probation, Respondent is prohibited from supervising physician assistants and advanced practice nurses.

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8. OBEY ALL LAWS. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

9. QUARTERLY DECLARATIONS. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

10. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Place of Practice

Respondent shall not engage in the practice of medicine in Respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal

Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event Respondent should leave the State of California to reside or to practice, Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

11. INTERVIEW WITH THE BOARD OR ITS DESIGNEE. Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

12. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If Respondent resides in California and is considered to be in non-practice, Respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve Respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete the Federation of State Medical Boards' Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

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Periods of non-practice for a Respondent residing outside of California will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing.

13. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

14. VIOLATION OF PROBATION. Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

15. LICENSE SURRENDER. Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

16. PROBATION MONITORING COSTS. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which

may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Thomas E. Still, Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 11/13/17

AYTAC HILMI APAYDIN, M.D.
Respondent

I have read and fully discussed with Respondent Aytac Hilmi Apaydin, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 11-13-2017

THOMAS E. STILL, Esq.
Attorney for Respondent

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ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

Dated: 11/14/17

Respectfully submitted,

XAVIER BECERRA
Attorney General of California

JANE ZACK SIMON
Supervising Deputy Attorney General
Attorneys for Complainant

SF2015401386

Exhibit A

Accusation No. 03-2013-234324

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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: **Aytac Hilmi Apaydin, M.D.** **1115 Los Palos Drive** **Salinas, CA 93901** **Physician's and Surgeon's Certificate No. A 46632,** Respondent.	Case No. 03-2013-234324 **FIRST AMENDED ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this First Amended Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about October 23, 1989, the Medical Board issued Physician's and Surgeon's Certificate Number A 46632 to Aytac Hilmi Apaydin, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2019, unless renewed.

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JURISDICTION

3. This First Amended Accusation (hereinafter "Accusation") is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2004 of the Code states, in relevant part:

"The board shall have the responsibility for the following:

"(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

"(b) The administration and hearing of disciplinary actions.

"(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

"(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

"(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board."

5. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

6. Section 2234 of the Code states, in relevant part:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

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"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence."

7. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

8. Section 725 of the Code provides that repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon.

FIRST CAUSE FOR DISCIPLINE

(Re: Patient DC)

(Unprofessional Conduct/Gross Negligence/Repeated Negligent Acts/Incompetence)

9. Respondent Aytac H. Apaydin, M.D., specializes in the practice of urology. At all times alleged in the Accusation, Respondent was engaged with a single partner, Stephen Worsham, M.D., in a medical practice called "Salinas Valley Urology Associates" located in Salinas, CA. Respondent has a financial interest in Advanced Medical Surgery Center in Salinas, where he performed many of the medical procedures and treatments on the patients discussed herein.

10. On or about January 3, 1995, Respondent first saw Patient DC, a 40-year-old man, upon referral for a complaint of left flank pain. On January 25, 1995, Respondent treated DC with left extracorporeal shock wave lithotripsy (ESWL) for renal stones. Subsequently, DC was found to have a left ureteropelvic junction obstruction for which Respondent performed a left retrograde endopyelotomy on September 13, 1996.

11. On July 21, 2006, following discovery of a palpable prostate nodule, Respondent performed a radical retropubic prostatectomy with bilateral pelvic lymph node dissection on Patient DC. The pathology report indicated that there was extension of cancer into the seminal vesicles. On July 29, 2006, DC underwent a cystoscopy performed by Respondent. Respondent's Operative Report noted that no strictures or lesions were seen in the anterior urethra and that no stones or lesions were seen in the bladder. During August and September 2007, DC received Intensity-modulated radiation therapy (IMRT), from another physician, to treat the pelvis and prostatic surgical bed. DC has had no recurrent clinical symptoms of prostate cancer and his PSAs tests have remained low and stable.

12. As a result of the surgery and radiation, DC developed stress urinary incontinence. Respondent scheduled DC for implantation of an artificial urinary sphincter (AUS) and hydrocelectomy. On February 2, 2010, Respondent performed a pre-op history and physical examination, noting that DC's past medical history included hip surgery and "some cardiac issues." No further details of DC's medical history are noted in the Pre-Op History and Physical Report. On the same date, Respondent took DC to surgery and discovered that DC had a bladder neck contracture. Respondent's Operative Report states that the procedure was changed to a bladder neck incision. Respondent documented that the bladder neck contracture was incised at 9 and 3 o'clock using a #21-French cystoscope and that a Foley catheter was placed and set to drainage. No further details of the procedure are documented in the Operative Report.

13. On March 2, 2010, DC had a CT of the abdomen and pelvis, without contrast, and x-ray examination of the urinary tract (urographyretrograde) due to right flank pain. The imaging revealed obstructing right ureteral stones and asymptomatic left renal stones. On this same date,

Dr. Stephen Worsham, Respondent's partner, performed cystoscopy and placed a ureteral stent on the right.

14. On March 15, 2010, Respondent performed a pre-op history and physical examination of DC in preparation for surgery to implant the urinary sphincter. Respondent noted DC's past medical history was "significant for cardiac disease, and GI disease." No further details of DC's medical history are documented and no pertinent details regarding DC's physical condition are noted in the report of the history and physical examination. On March 16, 2010, Respondent took DC to surgery and performed a right hydrocelectomy and he inserted an artificial urinary sphincter. Respondent's Operative Report fails to set forth indications for surgery and explanation of the timing of surgery.

15. Respondent's records document that on April 1, 2010, he treated DC with right ESWL for kidney stones. Respondent's "Operation Report" fails to document the imaging used to target the stones; the number of images taken; the number of the stones treated, and their location and size; DC's response to therapy; and, plans for follow up. At his Medical Board interview on January 7, 2015, Respondent reported that he does not wear a film badge during x-ray procedures.

16. Respondent's records document that on April 8, 2010, he treated DC with left ESWL for kidney stones. Respondent's Operation Report fails to document the imaging used to target the stones; the number of images taken; the number of the stones treated, and their location and size; DC's response to therapy; and, plans for follow up.

17. On April 19, 2010, Respondent saw DC for a follow up visit. Respondent noted that a KUB x-ray taken that day revealed no stones. Respondent's plan was to activate the sphincter.

18. On April 27, 2010, DC was seen by Respondent's partner, Dr. Worsham, for complaints of scrotal pain, redness, and swelling developed over the prior 24-48 hours. Dr. Worsham examined DC and ordered his admission to Salinas Valley Memorial Healthcare System (SVMHS) for suspected scrotal infection and infection of the urinary sphincter. Dr. Worsham documented discussion with DC of the likelihood of a significant infection that could require removal of the installed device. Dr. Worsham ordered, among other things, that broad

spectrum antibiotic therapy be initiated with gentamicin, vancomycin and Levaquin. Dr. Worsham ordered gentamicin and vancomycin be given "per pharmacy protocol."

19. On April 28, 2010, Respondent saw DC at the hospital and ordered IV antibiotics be continued. Respondent also ordered that a peripherally inserted central catheter (PICC) line be placed for intravenous (IV) administration of antibiotics at home and that arrangements be made for home IV administration of gentamicin and vancomycin for two (2) weeks. Respondent saw DC on April 29, 2010, and ordered his discharge from the hospital. Respondent's discharge orders included IV gentamicin and vancomycin "per pharmacy" and follow up/referral to home health nursing for IV antibiotic/PICC line care.

20. Respondent placed DC on a combination of parenteral antibiotics (vancomycin and gentamicin), each of which carries a risk of nephrotoxicity and/or ototoxicity. Prior to ordering DC's placement on these medications for two weeks, Respondent did not obtain a baseline creatinine clearance, nor did he perform an audiogram to determine DC's hearing function, nor did he seek an Infectious Disease consultation.

21. The service Access IV was selected to manage DC's antibiotic infusion at home. Respondent abdicated responsibility for the antibiotic dosing and follow-up monitoring to pharmacists with Access IV, who in turn determined the antibiotic dosage and intervals and who obtained blood tests to follow the patient. On April 30, 2010, DC was started on vancomycin 1,000 mg. via IV over 90 minutes every 12 hours, and gentamicin 440 mg. via IV over 60 minutes every 24 hours.

22. On May 12, 2010, Respondent saw DC and activated the artificial urinary sphincter. Respondent noted that DC was much better with no further evidence of infection. Respondent ordered that DC's treatment with antibiotics continue for two more weeks. Respondent's records indicate that the dosage of vancomycin was decreased to 800 mg. via IV every 12 hours.

23. Also on May 12, 2010, Respondent received lab test results from Access IV reporting, among other things, DC's creatinine level of 1.74 mg/dL (reference range 0.76-1.46 mg/dL). The laboratory results were accompanied by an inquiry from Access IV to Respondent which asked if Respondent wanted DC's vancomycin to be reduced from 800 mg. to 550 mg. via IV every 12

hours, and gentamicin to be reduced from 440 mg. to 250 mg. via IV every 24 hours. In a letter to the Medical Board of August 21, 2013 summarizing his care of Patient DC, Respondent reported that he "accepted" the "recommendation" of the Access IV pharmacist.

24. On Thursday, May 20, 2010, Access IV faxed to Respondent's office lab test results for Patient DC from blood drawn on May 18, 2010. The results revealed, among other things, a creatinine level of 3.02 mg/dL, BUN of 29 mg/dL (reference range 7-25 mg/dL), and eGFR of 22 mL/min (reference range >= 60 mL/min). The lab test results were accompanied by an inquiry to Respondent which asked if Respondent wanted to stop the patient's therapy now. Respondent's records document that on May 20th his partner, Dr. Worsham, ordered vancomycin and gentamicin, and the PICC line, be discontinued; that the patient have blood drawn May 21 and/or May 22 to test his creatinine level; and, that DC be seen by Respondent on Monday, May 24, 2010.

25. Respondent's records document that on May 21, 2010 he was notified of DC's condition and increased creatinine level, that the patient had been ordered to have lab tests done, and that the patient would be coming in to see him on May 24, 2010.

26. Respondent's records contain lab test results for Patient DC from May 21, 2010 (4:16 p.m.) reporting a creatinine level of 4.7 and a BUN of 41. The lab report contains "Comments" documenting that a covering MD was notified at approximately 9:34 p.m. of the test results. At his interview with the Medical Board on January 7, 2015, Respondent reported that he and his partner, Dr. Worsham, were off and/or out-of-town during the weekend of May 22 and 23, 2010, and that another physician was on-call for them. Respondent reported that the on-call physician did not call him to report DC's lab test results.

27. On May 24, 2010, Patient DC was admitted to SVMHS through the emergency department with complaints of weakness, dizziness, decreased appetite for at least two days, and lightheadedness with standing. Lab test results revealed a creatinine level of 4.9 and BUN of 48. A Nephrology consultation on May 25, 2010, noted that DC began experiencing severe vertigo one week prior. The consulting nephrologist assessed DC to be suffering from acute renal failure

most likely caused by immunoglycoside toxicity from exposure over the prior three weeks to gentamicin and vancomycin.

28. Patient DC was treated at the hospital with IV fluids, as-needed meclizine for his vertigo, and he was observed for expected improvement. Hospital records document that DC progressively improved on his own, and that his renal function improved during the hospitalization. On June 2, 2010, DC was deemed stable enough to go home and he was discharged from the hospital. However, DC continued to have ongoing complaints of vestibular dysfunction.

29. Respondent is guilty of unprofessional conduct and subject to disciplinary action under sections 2234, and/or 2234 (b), and/or 2234 (c), and/or 2234 (d) of the Code in that Respondent was grossly negligent, and/or he engaged in repeated negligent acts, and/or he was incompetent in the practice of medicine in his care and treatment of Patient DC, including but not limited to the following:

A. Respondent failed to assess DC's creatinine clearance prior to starting the patient on gentamicin and vancomycin.

B. Although DC was known to have a diminished renal function, Respondent chose antibiotics with a combined enhanced toxicity risk; and/or he failed to consider alternative antibiotics that would carry sufficient bacterial coverage with much less risk of toxicity than gentamicin and vancomycin.

C. Respondent failed to consult with a nephrology and/or infectious disease specialist at any time prior to DC's hospital admission on or about April 27, 2010.

D. Respondent abdicated responsibility for the choice of antibiotic dosing and intervals to a non-physician.

E. Respondent demonstrated a lack of knowledge regarding renal physiology in his management of Patient DC.

F. Respondent proceeded with the non-urgent artificial urinary sphincter implant prior to ascertaining that the bladder neck contracture had fully resolved.

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G. Respondent inadequately treated the bladder neck contracture when he used cautery, which induces further scarring and is likely to enhance recurrent scar tissue and bladder neck contracture, rather than resection, vaporization or deep incisions.

H. Respondent proceeded with the non-urgent artificial urinary sphincter implant prior to removing the ureteral stent and definitively treating DC's kidney stones.

I. Respondent failed to obtain baseline testing of DC's hearing and renal functions prior to initiating treatment with medications that carry potential toxicity.

J. Respondent failed to consider the potential impact prior treatment for an acoustic neuroma might have on DC's ototoxicity risks.

K. Respondent failed to perform and document an adequate history and physical examination on March 15, 2010.

L. Respondent failed to obtain and document informed consent with regard to the prescribing of antibiotic medications that carry risks of significant toxicity.

M. Respondent failed to inform and document that he advised DC of the opportunity to obtain consultation with an expert, such as infectious disease or nephrology or otolaryngology, who might have recommendations that would mitigate DC's risks.

N. Respondent failed to inform and document that he advised DC about choices in the sequence of therapies – bladder neck contracture, renal stone treatment, and artificial urinary sphincter – in order to permit DC to make informed choices to achieve his goals with the least possible risk.

O. Respondent failed to adequately and accurately document indications for the procedures and treatments he performed on Patient DC.

P. Respondent failed to document in his operative reports of ESWL treatments the indications for treatment, the number of stones treated, the location(s) and size(s) of the stones, DC's response to therapy, and plans for follow up.

Q. Respondent failed to wear a film badge during x-ray procedures of Patient DC.

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SECOND CAUSE FOR DISCIPLINE

(Re: Patient AC)

(Unprofessional Conduct/Gross Negligence/Repeated Negligent Acts/Incompetence/Excessive Treatment)

30. On or about October 10, 2007, Respondent first saw Patient AC, a 46-year-old man, upon referral for kidney stones. Respondent documented a history and physical examination and he diagnosed renal stones. The following day, Respondent's partner, Dr. Worsham, performed cystoscopy, a right retrograde ureteropyelography, and right ureteral stent placement. Respondent subsequently performed a right ESWL, on October 26, 2007, and a cystoscopy with stent removal on November 8, 2007.

31. Respondent's records include a hospital Emergency Room (ER) Report of October 28, 2011 from SVMHS documenting examination of Patient AC for a complaint of back pain. The ER Report notes that DC is overweight and that he is diabetic. A CT scan of the abdomen and pelvis revealed nonobstructing bilateral stones, 10 mm on the left and 12 mm on the right. AC was treated with pain medications and referred to his primary care physician (PCP) and Respondent for follow up.

32. Respondent saw DC on November 2, 2011. Vital signs were recorded and the abdomen was noted to be "soft and (tender?)." No further history and physical examination is noted. Respondent's plan was to perform left and right ESWL. On November 14, 2011, Respondent treated Patient AC with a right ESWL. Respondent's Operative Report fails to set forth indications for treatment and it fails to document the number of stones treated, their locations and size, AC's response to therapy, and plans for follow up. An X-ray Report by Respondent of the same date notes that images were obtained of the right kidney and that imaging was performed throughout the procedure. Respondent failed to document the number of x-rays taken during the procedure.

33. Between November 2011 through January 2013, Patient AC underwent six (6) separate left renal ESWL treatments and seven (7) separate right renal ESWL treatments performed by Respondent. Some of these treatment procedures were done as frequently as 17

days apart. For example, Respondent's records document that he performed left renal ESWL treatments on Patient AC on September 20, 2012 and on October 8 and 25, 2012; and, right renal ESWL treatments on April 23 and May 10, 2012. Respondent's Operative Reports for the ESWL treatments he performed on Patient AC fail to set forth indications for treatment and they fail to document the number of stones treated, their locations and size, AC's response to therapy and plans for follow up.

34. Between October 2011 and April 2013, Patient AC had at least 10 separate CT scans of the abdomen/pelvis and 23 separate KUB (kidney/ureter/bladder) x-rays of the abdomen taken at Respondent's request. These imaging studies were in addition to multiple x-rays and numerous fluoroscopic imaging studies performed by Respondent or at Respondent's request during stone treatments and other procedures (e.g., cystoscopy with stone manipulation, stent placement, stent removal). Respondent failed to document in the patient record the total number of x-rays taken and/or the total number of minutes of fluoroscopy for each of the treatments and procedures he performed on Patient AC.

35. Respondent's x-ray reports and operative reports appear cloned in that they are nearly identical in content with general descriptions that a procedure and/or treatment was performed and that x-rays were taken, with little or no additional details. Respondent's operative reports, at times, fail to adequately and/or accurately document the procedure performed and/or the rationale for performance of the procedures. For example, on multiple occasions Patient AC was given anesthesia simply to cystoscope the patient and remove an existing ureteral stent. Respondent failed to document indication in the record for the use of anesthesia for these manipulations and/or procedures. Respondent's Operative Report of December 1, 2012, states that he performed a cystoscopy, with right stent placement and stone manipulation. Respondent's description of the operation, however, does not reflect that any stone manipulation was performed.

36. On January 3, 2013, Respondent took Patient AC to the operating room and performed a cystoscopy with stent removal under anesthesia. Respondent's records indicate that approximately two hours later on the same date, Respondent again took the patient to surgery and performed a cystoscopy, ureteroscopy, stone extraction, and stent placement. Respondent failed

to document in the record why these two procedures could not have been performed at the same time under the same anesthetic.

37. Respondent is guilty of unprofessional conduct and subject to disciplinary action under sections 2234, and/or 2234 (b), and/or 2234 (c), and/or 2234 (d), and/or 725 of the Code in that Respondent was grossly negligent, and/or he engaged in repeated negligent acts, and/or he was incompetent, and/or he performed excessive diagnostic tests and/or excessive treatments in the practice of medicine in his care and treatment of Patient AC, including but not limited to the following:

A. Respondent failed throughout his care of Patient AC to identify the causes of AC's stones with blood tests and/or 24-hour urine collection to measure stone elements.

B. Respondent failed to address and treat Patient AC's persistent urine pH of 5.0 or 5.5.

C. Respondent performed an excessive number of ESWL treatments on Patient AC.

D. Respondent placed Patient AC at increased risk for long-term renal damage and/or other potential complications when he performed ESWL treatments as frequently as every 17-20 days.

E. Respondent failed to progress to other therapies when multiple ESWL treatments were unsuccessful.

F. Respondent repeatedly used general anesthesia for cystoscopy and stent removal in the absence of unique anatomy or other indications for the use of general anesthesia; and/or Respondent failed to document indication for the use of general anesthesia during such procedures.

G. Respondent engaged in repeated acts of clearly excessive use of diagnostic tests and/or imaging studies with no attempt to minimize radiation exposure to the patient.

H. Respondent failed to obtain and document informed consent with regard to the excessive treatments and excessive diagnostic tests and/or imaging studies, and/or with regard to options for alternative treatments.

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I. Respondent failed to perform and document an adequate history and physical examination, and/or he failed to document indications for therapy or treatment and/or details of the procedures and treatment he performed.

J. Respondent failed to document in his operative reports of ESWL treatments the indications for treatment, the number of stones treated, the location(s) and size(s) of the stones, AC's response to therapy, and plans for follow-up.

K. Respondent failed to document in the patient record the number of x-rays taken and/or the total number of minutes of fluoroscopy for the treatments and procedures he performed on Patient AC.

L. On January 3, 2013, Respondent performed two separate procedures under anesthesia at different times. Respondent failed to perform the two procedures at the same time, or, he failed to document in the patient record why the two procedures could not have been performed at the same time under the same anesthetic.

M. Respondent failed to disclose, and/or he failed to document that he disclosed, his financial interest in Advanced Medical Surgery Center, where he performed most of the surgical procedures and treatments on Patient AC.

N. Respondent failed to wear a film badge during x-ray procedures of Patient AC.

THIRD CAUSE FOR DISCIPLINE

(Patient RM)

(Unprofessional Conduct/Gross Negligence/Repeated Negligent Acts/Incompetence/Excessive Treatment)

38. On or about July 9, 2009, Respondent first saw Patient RM, a 22-year-old woman, upon referral for treatment of kidney stones revealed during a hospital emergency room visit. Respondent documented performance of a history and physical examination, and diagnosis of bilateral stones. On this same date, Respondent performed cystoscopy, right ureteroscopy, stone manipulation and stent placement.

39. Respondent continued to see patient RM for stone disease through approximately February 2013. During this time period, Respondent performed two separate right renal ESWL

treatments and five separate left renal ESWL treatments. On one occasion, left renal ESWL treatments were performed nine days apart, on April 3 and 12, 2012. Respondent performed multiple ureteroscopy and stent placements while x-rays confirmed very small stones that could have been best managed conservatively with non-invasive treatment.

40. Respondent's Operative Reports for the ESWL treatments he performed on Patient RM fail to set forth indications for treatment and they fail to document the number of stones treated, their locations and size, RM's response to therapy, and plans for follow up.

41. Between July 2009 and February 2013, Patient RM had at least three separate CT scans of the abdomen/pelvis, including one on October 21, 2009 requested by Respondent and one on October 22, 2009, requested by Respondent's partner, Dr. Worsham. On November 16, 2012, Patient RM had a CT scan of the abdomen/pelvis done at Respondent's request. Patient RM was pregnant at the time this particular CT scan was done. Respondent did not perform a blood test, or any other test, to determine whether RM was pregnant prior to ordering the CT scan that was done on November 16, 2012.

42. Patient RM had 10 separate KUB x-rays taken of the abdomen at Respondent's request, in addition to three KUB abdominal x-rays taken at the request of Respondent's partner, Dr. Worsham, during this same time period. These imaging studies were in addition to x-rays and fluoroscopic imaging studies performed during stone treatments and other procedures performed by Respondent. Respondent's operative reports and x-ray reports fail to document the number of x-rays taken and/or the total number of minutes of fluoroscopy for the treatments and procedures he performed on Patient RM.

43. On April 6, 2012, Respondent performed cystoscopy with stent removal under anesthesia. Cystoscopy with stent removal is a minor procedure that requires little more than urethral lidocaine jelly topical anesthesia unless there are extraordinary circumstances. Respondent failed to document indication for the use of anesthesia.

44. During the over three years Respondent treated Patient RM, he never obtained blood tests to determine the cause for Patient RM's stones, no measure of her parathyroid level was

made, no analysis of any stones was done to determine their makeup, and no 24-hour urine collection was done to measure stone-elements to assist in metabolic management.

45. Respondent's operative reports and x-ray reports appear to be cloned documents nearly identical in content with general descriptions that a treatment and/or procedure was performed and x-rays were taken, with little or no additional details.

46. Respondent is guilty of unprofessional conduct and subject to disciplinary action under sections 2234, and/or 2234 (b), and/or 2234 (c), and/or 2234 (d), and/or 725 of the Code in that Respondent was grossly negligent, and/or he engaged in repeated negligent acts, and/or he was incompetent, and/or he performed excessive diagnostic tests and/or excessive treatments in the practice of medicine in his care and treatment of Patient RM, including but not limited to the following:

A. Respondent failed throughout his care of Patient RM to identify the causes of RM's stones with blood tests and/or 24-hour urine collection to measure stone elements; and/or he failed to obtain analysis of the stones to determine their makeup.

B. Respondent failed to determine whether RM was pregnant prior to performing the CT scan on November 16, 2012, and/or Respondent had the CT scan done when Patient RM was pregnant.

C. Respondent performed an excessive number of ESWL treatments and/or interventional procedures on Patient RM.

D. Respondent placed Patient RM at increased risk for renal injury when he performed ESWL treatments nine days apart, on April 3 and 12, 2012.

E. Respondent failed to progress to other therapies when multiple ESWL treatments were unsuccessful.

F. Respondent used general anesthesia for cystoscopy and stent removal in the absence of unique anatomy or other indications for the use of general anesthesia; and/or Respondent failed to document indication for the use of general anesthesia during the procedure.

G. Respondent performed an excessive number of imaging studies with no attempt to minimize radiation exposure to the patient.

H. Respondent failed to either consult with and/or to refer the patient to another physician for more expert evaluation regarding the medical causes for the patient's stones and for treatment.

I. Respondent failed to document in the patient record indications for therapy or treatment, and/or details of the procedures and treatments he performed.

J. Respondent failed to document in his operative reports of ESWL treatments the indications for treatment, the number of stones treated, the location(s) and size(s) of the stones, RM's response to therapy, and plans for follow up.

K. Respondent failed to document in the patient record the number of x-rays taken and/or the total number of minutes of fluoroscopy for the treatments and procedures he performed on Patient RM.

L. Respondent failed to disclose, and/or he failed to document that he disclosed, his financial interest in Advanced Medical Surgery Center, where he performed many of the surgical procedures and treatments on Patient RM.

M. Respondent failed to wear a film badge during x-ray procedures of Patient RM.

FOURTH CAUSE FOR DISCIPLINE

(Re: Patient SV)

(Unprofessional Conduct/Gross Negligence/Repeated Negligent Acts/Incompetence)

47. On May 20, 2015, Patient SV, a 68-year-old woman with a history of urolithiasis, was seen in the Emergency Department (ED) at Salinas Valley Memorial Hospital with complaints of severe right flank pain and hematuria. A CT scan showed a 2-mm stone in the right ureterovesical junction without hydronephrosis and a stable 4-mm non-obstructing left lower pole renal stone. There were no changes in the left renal stone between 01/17/2014 and 05/20/2015. The patient was treated conservatively, prescribed Norco for pain, referred for follow up to Respondent's partner, Dr. Worsham, and discharged without urologic consultation.

48. On September 28, 2015, Patient SV was brought by ambulance to the Salinas Valley Memorial Hospital ED with complaints of severe pain on the left side radiating to the back, nausea, and vomiting. Microscopic urinalysis showed 10-25 WBC and 100-200 RBC. A CT

scan revealed a 2.5-mm stone at the left ureterovesical junction with mild hydronephrosis. The same non-obstructing stone was seen in the left lower pole of the kidney that had been noted in May. The patient was provided IV Toradol and oral Flomax. She was discharged home with planned conservative therapy, anticipating spontaneous passage, prescribed Norco for pain, and referred to Respondent for follow up.

49. Later that same day, September 28, 2015, Respondent saw Patient SV. Respondent's progress note documents that the patient was seen in the ED "last night." No update on the severity of SV's pain, location of the pain, presence or absence of nausea or vomiting, or presence or absence of fever or chills is noted in the record. Nothing in the documented physical examination indicates that the patient was in extreme pain or stress. Patient SV was scheduled for invasive therapy later that date. Respondent failed to discuss and/or to document discussion about anticipating spontaneous passage of the stone or the pros and cons of conservative therapy versus invasive therapy or a recommended a course of expectant conservative therapy.

50. On September 28, 2015, Patient SV appeared at Respondent's Advanced Medical Surgery Center, where she was given preoperative IV Ancef and placed under anesthesia. Respondent's Operative Report states that he used fluoroscopic imaging to perform a cystoscopy, left stone manipulation, and left stent placement. Respondent's Operative Report does not explain "stone manipulation." Respondent failed to indicate in his Operative Report whether the stone was seen, basketed, lasered, retrieved, or obstructing. No characterization or outcome of the stone nor of Respondent's findings is noted in the Report. Respondent failed to state in his Operative Report the size, length, caliber and/or nature of the ureteral stent. Respondent also prepared a Fluoroscopy and X-Ray Report regarding the procedure. Respondent failed to indicate in the radiology report whether the patient had stones identified, their location and size, the presence or absence of obstruction, nor any other clinical information relating to Respondent's findings.

51. Both the Anesthesia Record and Intraoperative Nursing Record for SV's procedure on September 28, 2015 state that surgery start time was 1632 and end time was 1634, for a total surgery time of two (2) minutes. It appears that Respondent has misstated and/or

mischaracterized the procedure performed on September 28, 2015, as it is medically inconceivable that the patient was cystoscoped, had a ureteral guidewire placed, had a ureteroscope manipulated retrograde over a guidewire, had a stone manipulated, and had a ureteral stent left in place, all within two (2) minutes.

52. Patient SV was discharged home with oral antibiotics following the procedure on September 28, 2015. She had a blood test done in early October 2015 and a KUB x-ray on October 9, 2015. The KUB film revealed that the left stent was visualized and there was evidence of a "small calcification" in the lower pole of the left kidney but no other stones were seen.

53. On October 12, 2015, Patient SV returned to see Respondent for a scheduled left ESWL. Respondent did not obtain a urinalysis or culture of the urine prior to the scheduled treatment. The patient requested but was not given the opportunity to discuss with Respondent the procedure to be performed. Instead, the patient was taken to Respondent's Advanced Medical Surgery Center where she was placed under general anesthesia and Respondent performed a left ESWL. Respondent's Operative Report fails to state what was treated, what indications were present, what findings were noted, what the outcomes were, and what follow up was planned. The Operative Note fails to indicate whether Respondent treated a ureteral stone, the renal stone, or a bladder finding. Respondent's X-Ray Report of the procedure fails to describe whether a stone was seen, the stone size and location, response to ESWL, nor postoperative findings. Patient SV was not given further antibiotics when she was discharged following the procedure.

54. The following morning, October 13, 2015, Patient SV began experiencing pain while voiding and back pain. She contacted Respondent's office, was prescribed Pyridium, and advised to come to the office the next day. That same evening SV's pain increased, she became feverish, and she experienced nausea and vomiting. SV appeared at Respondent's office in severe pain the next morning, October 14, 2015, and was told that Respondent was not yet in the office. SV then went directly to the ED at Salinas Valley Memorial Hospital.

55. ED records indicate that Patient SV complained of left flank pain, nausea, vomiting, fever, and chills. Her left flank pain was constant and severe. She was noted to be febrile with a mildly elevated white blood cell count. Her urinalysis revealed white blood cells, red blood cells,

and bacteria. The urine culture ultimately grew E. coli sensitive to all tested antibiotics. SV was treated with IV Rocephin. Upon consultation with Respondent, the hospitalist admitted the patient for IV fluids and antibiotics. A noncontrast CT on October 14, 2015 indicated the presence of a left ureteral stent without hydronephrosis. A 2 to 3-mm calcification was seen in the left lower pole of the kidney. The previously noted 3-mm distal left ureteral stone was no longer seen in the ureter or the bladder. There was perinephric stranding around the left kidney. No pathology was identified on the right.

56. By October 15, 2015, SV was much improved. She had further febrile spikes that day, but overall felt much better. By October 16, 2015 SV was switched to oral Levaquin 750 mg. for seven days based on her urine culture. She was notably improved and discharged home that day on oral antibiotics.

57. Patient SV did not return to see Respondent. Patient SV was treated by another physician for removal of the ureteral stent.

58. Respondent is guilty of unprofessional conduct and subject to disciplinary action under sections 2234, and/or 2234 (b), and/or 2234 (c), and/or 2234 (d) of the Code in that Respondent was grossly negligent, and/or he engaged in repeated negligent acts, and/or he was incompetent in the practice of medicine in his care and treatment of Patient SV, including but not limited to the following:

A. Respondent rushed Patient SV to surgery on September 28, 2015 for treatment of a stone that would have been expected to pass spontaneously. Respondent failed to afford the patient a reasonable interval of conservative therapy before concluding such therapy was failing and that invasive therapy was required.

B. Respondent lacked indication for ESWL treatment on October 12, 2015 on a 4-mm or smaller left renal stone that had been asymptomatic and non-obstructing.

C. Respondent failed to discuss and/or to document discussion with SV of conservative therapy options, including watchful waiting and the possibility of the stone passing spontaneously, prior to taking the patient to surgery on September 28, 2015.

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D. Respondent failed to examine the patient prior to treatment and/or he failed to completely and thoroughly discuss with SV and/or to document a complete and thorough discussion of the necessity for treatment and/or treatment options prior to the ESWL treatment on October 12, 2015.

E. Respondent failed to obtain a urinalysis and, if necessary, a culture of the urine prior to the ESWL treatment on October 12, 2015.

F. Respondent has misstated and/or mischaracterized the procedures he performed and documented in his Operative Report of September 28, 2015, and/or he documented procedures that the did not actually perform.

G. Respondent failed to document on September 28, 2015 an update of Patient SV's physical status and response to treatment following her visit to the ED earlier that day; and/or he failed to document indication for the procedures he performed; and/or he failed to document in his Operative Report and Fluoroscopy and X-Ray Report clinical information relating to his findings and treatment and details of the procedures performed.

H. Respondent failed to document in his Operative Report and/or X-Ray Report of October 12, 2015 indication for the ESWL treatment and/or he failed to document clinical information relating to his findings and treatment and details of the treatment.

FIFTH CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

59. The allegations of the First, Second, Third, and Fourth Causes for Discipline, above, are incorporated herein by reference as if fully set forth.

60. Respondent is guilty of unprofessional conduct and subject to disciplinary action under section 2234 (c) of the Code in that Respondent committed repeated negligent acts in his care and treatment of Patients DC and/or AC and/or RM and/or SV, as alleged in the First and/or Second and/or Third and/or Fourth Causes for Discipline.

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SIXTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

61. The allegations of the First, Second, Third, and Fourth Causes for Discipline, above, are incorporated herein by reference as if fully set forth.

62. Respondent is guilty of unprofessional conduct and subject to disciplinary action under section 2266 of the Code in that Respondent failed to maintain adequate and accurate records with regard to his care and treatment of Patients DC and/or AC and/or RM and/or SV, as alleged in the First and/or Second and/or Third and/or Fourth Causes for Discipline.

DISCIPLINARY CONSIDERATIONS

63. To determine the degree of discipline, if any, to be imposed on Respondent Aytac Hilmi Apaydin, M.D., Complainant alleges that on or about January 25, 2013, in a prior disciplinary action entitled *In the Matter of the Accusation Against Aytac Apaydin, M.D.* before the Medical Board of California, in Case Number 03-2010-211094, Respondent's license was publically reprimanded and he was ordered to complete a medical record keeping course. The discipline was for Respondent's failure to discover that a piece of wire was left in a patient's bladder following a cystoscopy, and for failing to maintain adequate records. That decision is now final and is incorporated by reference as if fully set forth herein.

64. To determine the degree of discipline, if any, to be imposed on Respondent Aytac Hilmi Apaydin, M.D., Complainant alleges that on or about May 1, 2008, in a prior disciplinary matter entitled *In the Matter of the Public Letter of Reprimand Issued to: Aytac Hilmi Apaydin, M.D.* before the Medical Board of California, in Case Number 03-2006-174314, Respondent was issued a Public Letter of Reprimand for altering a patient's medical records and for failing to inform the patient of the side effects of Lupron. That matter is now final and is incorporated by reference as if fully set forth herein.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 46632, issued to Aytac Hilmi Apaydin, M.D.;

2. Revoking, suspending or denying approval of Aytac Hilmi Apaydin, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Aytac Hilmi Apaydin, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and,

4. Taking such other and further action as deemed necessary and proper.

DATED: November 1, 2017

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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